

STATE OF ILLINOIS

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Facility Name & ID Number Alden Des Plaines Rehab & HC# 0042010 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>110</u>	Skilled (SNF)	<u>110</u>	<u>40,150</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>110</u>	TOTALS	<u>110</u>	<u>40,150</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,846</u>	<u>6,488</u>	<u>18,413</u>	<u>26,747</u>	8
9	SNF/PED					9
10	ICF	<u>7</u>	<u>802</u>		<u>809</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,853</u>	<u>7,290</u>	<u>18,413</u>	<u>27,556</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 68.63%

D. How many bed-hold days during this year were paid by Public Aid?

none (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/31/2000

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 10/31/2000 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 85 and days of care provided 18,382Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number

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Report Period Beginning:

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V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	499,672	32,380	3,180	535,232	867	536,099		536,099		1
2	Food Purchase		244,062		244,062	(22,358)	221,704	1,258	222,962		2
3	Housekeeping	96,921	22,271		119,192	444	119,636		119,636		3
4	Laundry	40,435	11,256		51,691	72	51,763		51,763		4
5	Heat and Other Utilities			172,854	172,854		172,854	(462)	172,392		5
6	Maintenance	45,858		87,910	133,768	137	133,905	5,407	139,312		6
7	Other (specify):* Security			94	94		94		94		7
8	TOTAL General Services	682,886	309,969	264,038	1,256,893	(20,838)	1,236,055	6,203	1,242,258		8
	B. Health Care and Programs										
9	Medical Director			43,200	43,200		43,200		43,200		9
10	Nursing and Medical Records	1,889,467	146,756	9,040	2,045,263	4,518	2,049,781	(86,565)	1,963,216		10
10a	Therapy	61,882			61,882		61,882		61,882		10a
11	Activities	79,866	2,409	4,237	86,512	97	86,609		86,609		11
12	Social Services	38,836			38,836		38,836		38,836		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,070,051	149,165	56,477	2,275,693	4,615	2,280,308	(86,565)	2,193,743		16
	C. General Administration										
17	Administrative	138,227			138,227		138,227		138,227		17
18	Directors Fees										18
19	Professional Services			690,822	690,822	(6,890)	683,932	(667,067)	16,865		19
20	Dues, Fees, Subscriptions & Promotions			40,582	40,582		40,582	(34,253)	6,329		20
21	Clerical & General Office Expenses	382,984	18,809	66,432	468,225	242	468,467	(2,675)	465,792		21
22	Employee Benefits & Payroll Taxes			412,015	412,015	15,981	427,996	21,876	449,872		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,093	2,093		2,093	5,751	7,844		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			71,001	71,001		71,001	12,048	83,049		26
27	Other (specify):* Bad debt expense			93,110	93,110		93,110	(93,110)			27
28	TOTAL General Administration	521,211	18,809	1,376,055	1,916,075	9,333	1,925,408	(757,430)	1,167,978		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,274,148	477,943	1,696,570	5,448,661	(6,890)	5,441,771	(837,792)	4,603,979		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Report Period Beginning:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			59,089	59,089		59,089	232,947	292,036			30
31	Amortization of Pre-Op. & Org.							1,060	1,060			31
32	Interest			205,002	205,002		205,002	365,072	570,074			32
33	Real Estate Taxes					6,890	6,890	348,099	354,989			33
34	Rent-Facility & Grounds			1,272,261	1,272,261		1,272,261	(1,272,261)				34
35	Rent-Equipment & Vehicles			13,303	13,303		13,303	10,600	23,903			35
36	Other (specify):* Mtge insurance							36,992	36,992			36
37	TOTAL Ownership			1,549,655	1,549,655	6,890	1,556,545	(277,491)	1,279,054			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		882,217	1,312,444	2,194,661		2,194,661	(376,477)	1,818,184			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		882,217	1,372,669	2,254,886		2,254,886	(376,477)	1,878,409			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,274,148	1,360,160	4,618,894	9,253,202		9,253,202	(1,491,760)	7,761,442			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(90,935)	30		9
10 Interest and Other Investment Income	(626)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(5,385)	2		13
14 Non-Care Related Interest	(128,400)	32		14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees	(431)	21		17
18 Fines and Penalties	(26,087)	32		18
19 Entertainment	(3,694)	20		19
20 Contributions	(444)	20		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers	(5,611)	19		22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(93,110)	27		24
25 Fund Raising, Advertising and Promotional	(28,734)	20		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule				29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (383,457)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(855,044)		34
35 Other- Attach Schedule	(253,259)	pg 5A	35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (1,108,303)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (1,491,760)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Alden Des Plaines Rehab & HC

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late fees on utilities	\$ (818)	5	1
2	Beauty/barber income (gl 4630-4631)	(1,357)	5	2
3	Other nursing income	(256)	21	3
4	Intercompany interest (gl 7031)	(39,000)	32	4
5	Miscellaneous income (gl 4977)	(35)	21	5
6	IL Health Care Assoc dues (PAC: 30.13%)	(1,641)	20	6
7	Marketing Mgr (gl 6701-100-009)	(74,209)	21	7
8	Reclass Vendor settlement from line 21 to line 10	792	21	8
9	Reclass Vendor settlement from line 21 to line 10	(792)	10	9
10	Back out prior yr exp credit adj (Promed)	792	10	10
11	Reclass Vendor settlement from line 6 to line 10	21	6	11
12	Reclass Vendor settlement from line 6 to line 10	(21)	10	12
13	Back out prior yr exp credit adj (Air Filter Eng)	21	10	13
14	Reclass exp (cr) from line 21 to line 20 (pr yr info)	522	21	14
15	Reclass exp (cr) from line 21 to line 20 (pr yr info)	(522)	20	15
16	Reclass exp (cr) from line 21 to line 20 (Chi Trib)	522	20	16
17	Adj deferred maintenance exp to equal page 22's	715	6	17
18	Back out LP mtge int > CON asset limit	(207,815)	32	18
19	Back out LP MIP exp > CON asset limit	(14,344)	36	19
20	Back out prior yr LP rent adj	71,776	34	20
21	Back out prior yr LP rent adj	22,980	34	21
22	Mktg Mgr employee benefits reduction (.023)	(10,590)	22	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(253,259)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning:

01/01/2003

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12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,385)	0	0	6,643	0	0	0	0	0	0	0	1,258	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,175)	0	1,713	0	0	0	0	0	0	0	0	(462)	5
6	Maintenance	736	0	5,564	0	0	0	(39)	(854)	0	0	0	5,407	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,824)	0	7,277	6,643	0	0	(39)	(854)	0	0	0	6,203	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(85,532)	(1,033)	0	0	0	0	0	0	(86,565)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	(85,532)	(1,033)	0	0	0	0	0	0	(86,565)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,611)	5,744	(667,200)	0	0	0	0	0	0	0	0	(667,067)	19
20	Fees, Subscriptions & Promotions	(34,513)	0	260	0	0	0	0	0	0	0	0	(34,253)	20
21	Clerical & General Office Expenses	(73,617)	0	15,275	33,050	22,617	0	0	0	0	0	0	(2,675)	21
22	Employee Benefits & Payroll Taxes	(10,590)	0	27,311	0	5,155	0	0	0	0	0	0	21,876	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,751	0	0	0	0	0	0	0	0	5,751	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	11,915	133	0	0	0	0	0	0	0	0	12,048	26
27	Other (specify):*	(93,110)	0	0	0	0	0	0	0	0	0	0	(93,110)	27
28	TOTAL General Administration	(217,441)	17,659	(618,470)	33,050	27,772	0	0	0	0	0	0	(757,430)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(224,265)	17,659	(611,193)	(45,839)	26,739	0	(39)	(854)	0	0	0	(837,792)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(90,935)	311,477	10,584	0	1,821	0	0	0	0	0	0	232,947	30
31	Amortization of Pre-Op. & Org.	0	0	773	0	0	287	0	0	0	0	0	1,060	31
32	Interest	(401,928)	741,635	22,857	0	2,074	434	0	0	0	0	0	365,072	32
33	Real Estate Taxes	0	344,023	3,213	0	863	0	0	0	0	0	0	348,099	33
34	Rent-Facility & Grounds	94,756	(1,367,017)	0	0	0	0	0	0	0	0	0	(1,272,261)	34
35	Rent-Equipment & Vehicles	0	0	10,600	0	0	0	0	0	0	0	0	10,600	35
36	Other (specify):* Mtge Insurance	(14,344)	51,336	0	0	0	0	0	0	0	0	0	36,992	36
37	TOTAL Ownership	(412,451)	81,454	48,027	0	4,758	721	0	0	0	0	0	(277,491)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(76,261)	(97,375)	(202,841)	0	0	0	0	0	(376,477)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(76,261)	(97,375)	(202,841)	0	0	0	0	0	(376,477)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(636,716)	99,113	(563,166)	(122,100)	(65,878)	(202,120)	(39)	(854)	0	0	0	(1,491,760)	45

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0042010

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc	100	See Page 6K		See Page 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent	\$ 1,367,017	Alden-Des Plaines Rehab. And Health Care Center, LLC	100.00%	\$	\$ (1,367,017)
2	V	32 Interest Income - R/R	563	Alden-Des Plaines Rehab. And Health Care Center, LLC			(563)
3	V	19 Accounting fees		Alden-Des Plaines Rehab. And Health Care Center, LLC		3,800	3,800
4	V	33 Real estate taxes		Alden-Des Plaines Rehab. And Health Care Center, LLC		344,023	344,023
5	V	26 Property & liability insurance		Alden-Des Plaines Rehab. And Health Care Center, LLC		11,915	11,915
6	V	32 Interest on mortgage		Alden-Des Plaines Rehab. And Health Care Center, LLC		742,198	742,198
7	V	36 Mortgage insurance premium		Alden-Des Plaines Rehab. And Health Care Center, LLC		51,336	51,336
8	V	30 Depreciation		Alden-Des Plaines Rehab. And Health Care Center, LLC		311,477	311,477
9	V	19 Miscellaneous expense		Alden-Des Plaines Rehab. And Health Care Center, LLC		1,944	1,944
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 1,367,580			\$ 1,466,693	\$ * 99,113

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Des Plaines Rehab & HC

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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee benefits	\$	Alden Management Services	0.00%	\$ 27,311	\$ 27,311	15
16	V	19 Professional fees	674,804	Alden Management Services		7,604	(667,200)	16
17	V	21 Clerical & general		Alden Management Services		15,275	15,275	17
18	V	5 Utilities		Alden Management Services		1,713	1,713	18
19	V	6 Maintenance		Alden Management Services		5,564	5,564	19
20	V	24 Travel & seminar		Alden Management Services		5,751	5,751	20
21	V	26 Insurance		Alden Management Services		133	133	21
22	V	20 Dues/fees/subscriptions		Alden Management Services		260	260	22
23	V	30 Depreciation		Alden Management Services		10,584	10,584	23
24	V	31 Amortization		Alden Management Services		773	773	24
25	V	33 Real estate taxes		Alden Management Services		3,213	3,213	25
26	V	35 Rent-equipment/vehicles		Alden Management Services		10,600	10,600	26
27	V	32 Interest		Alden Management Services		22,857	22,857	27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 674,804			\$ 111,638	\$ * (563,166)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 tube-feeding	\$ 3,200	Pyramid Health Care	100.00%	\$ 9,843	\$ 6,643	15
16	V	10 nursing supplies	88,213	Pyramid Health Care		2,681	(85,532)	16
17	V	39 per diems/other supplies	165,784	Pyramid Health Care		89,523	(76,261)	17
18	V	21 gen'l & admin		Pyramid Health Care		33,050	33,050	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 257,197			\$ 135,097	\$ * (122,100)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 drugs	\$ 352,438	Forum Extended Care II	100.00%	\$ 297,743	\$ (54,695)
16	V	10 house sock	6,671	Forum Extended Care II		5,638	(1,033)
17	V	39 I. V.	275,018	Forum Extended Care II		232,338	(42,680)
18	V	22 Employee Benefits		Forum Extended Care II		5,155	5,155
19	V	21 Gen'l & admin		Forum Extended Care II		22,617	22,617
20	V	32 interest		Forum Extended Care II		2,074	2,074
21	V	33 real estate tax		Forum Extended Care II		863	863
22	V	30 depreciation		Forum Extended Care II		1,821	1,821
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 634,127			\$ 568,249	\$ * (65,878)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 therapy	\$ 1,271,787	Community Physical Therapy	100.00%	\$ 1,068,946	\$ (202,841)
16	V	32 interest		Community Physical Therapy		434	434
17	V	31 amortization		Community Physical Therapy		287	287
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,271,787			\$ 1,069,667	\$ * (202,120)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 repairs and maintenance	\$ 12,212	Alden Bennett Construction	100.00%	\$ 12,173	\$ (39)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 12,212			\$ 12,173	\$ * (39)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 CARPET CLEANING	\$ 9,295	ALDEN REALTY - CARPET CARE		\$ 8,650	\$ (645)	15
16	V	6 FLOOR CLEANING	3,680	ALDEN REALTY - FLOOR CARE		3,471	(209)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 12,975			\$ 12,121	\$ * (854)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number ALDEN NURSING CENTER - Des Plaines

42010

Report Period Beginning 01/01/03

Ending: 12/31/03

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomington
ANC Village for Children & Young Adults	Bloomington
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomington
Alden of Old Town West	Bloomington
Alden Trails	Bloomington
Alden Northshore	Skokie
ANC Waterford	Aurora
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC Governor's Park	Barrington

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

STATE OF ILLINOIS

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Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive	36.00	337,646	1.028	2.57	SALARY	\$ 8,906	17-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	1.00	84,828	1.028	2.57	SALARY	2,237	10-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	1.00	82,030	1.028	2.57	SALARY	2,164	6-1	3
4	Joan Carl d.	Secretary	Vice-President	9.00	212,529	1.028	2.57	SALARY	5,606	17-1	4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12											12
13								TOTAL	\$ 18,913		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.
 Street Address 4200 W. Peterson Ave.
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773) 286-3883
 Fax Number (773) 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	See Page 8A (also on Page 6A)				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Cambridge		X	Mortgage	\$66,537.00	1/1/02	\$ 10,390,300	\$ 10,282,340	6/1/2040	7.2000	\$ 742,198	1							
2				Int exp in excess of CON cap							(207,815)	2							
3												3							
4	Related party-AMS	X		Working capital							1,647	4							
5	Bank Leumi		X	Working capital	varies	10/16/03	1,150,000	1,120,000	5/31/2004	4.5000	9,868	5							
	Working Capital																		
6	Related party-AMS	X		Working capital							22,857	6							
7	Related party-FECH	X		Working capital							2,074	7							
8	Related party-CPT	X		Working capital							434	8							
9	TOTAL Facility Related				\$66,537.00		\$ 11,540,300	\$ 11,402,340			\$ 571,263	9							
	B. Non-Facility Related*																		
10	DP Rehab & HCC, LLC	X		Non-care interest income							(563)	10							
11	Offset interest exp with interest inc on Corp's books										(626)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (1,189)	14							
15	TOTALS (line 9+line14)						\$ 11,540,300	\$ 11,402,340			\$ 570,074	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 36,992 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	190,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	261,776	2
3. Under or (over) accrual (line 2 minus line 1).			\$	71,776	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	272,247	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	6,890	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	350,913	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1998		8	
		1999	11,326	9	
		2000	5,663	10	
		2001	112,958	11	
		2002	261,776	12	
Accrual based on 4% increase over prior year bills.				13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Des Plaines Rehab & HC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042010

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773) 586-3883 FAX #: (773) 286-3743

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-17-200-128-0000</u>	<u>Nursing home facility</u>	\$ <u>160,600.42</u>	\$ <u>160,600.42</u>
2. <u>09-17-200-129-0000</u>	<u>Nursing home facility</u>	\$ <u>101,175.99</u>	\$ <u>101,175.99</u>
3. _____	<u>Related Party-Alden Mgmt Serv</u>	\$ <u>125,008.00</u>	\$ <u>3,213.00</u>
4. _____	<u>Related Party-Forum</u>	\$ <u>8,258.00</u>	\$ <u>863.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>395,042.41</u></u>	\$ <u><u>265,852.41</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
51,490

B. General Construction Type:

Exterior
Brick

Frame
Steel

Number of Stories
2

C.
Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☐ (a) Own the Equipment
☐ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing home	51,490	2000	\$ 1,016,045	1
2					2
3	TOTALS	51,490		\$ 1,016,045	3

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6	110		2000	2000	6,986,060	242,149	40	174,655	(67,494)	635,926	6
7											7
8		Related party-Forum		1978	15,909		22			15,909	8
		Improvement Type**									
9		ISS/Chicago Sound & Communication(vent alarm interface)		2000	3,400	340	10	340		1,247	9
10		Alden Bennett Construction(multiple wireless install)		2001	4,894	489	10	489		1,305	10
11		Owners extras		2000	524,876	26,244	20	26,244		89,666	11
12		Owners extras		2000	12,972	648	20	648		2,216	12
13		ABC-parking lot sealcoat/stripe		2002	3,852	550	7	550		780	13
14		ABC-screened patio enclosure		2002	10,069	1,438	7	1,438		2,638	14
15		EWS Welding-alarm		2002	1,076	108	10	108		215	15
16		New Horizons-residents phones		2002	1,646	165	10	165		274	16
17		New Horizons-residents phones		2002	3,161	316	10	316		501	17
18		ABC-owners extras		2003	2,571	171	15	171		171	18
19		ABC-owners extras		2003	5,511	367	15	367		367	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,575,997	\$ 272,985		\$ 205,491	\$ (67,494)	\$ 751,215	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	16,755		20			16,755	4
5	Leasehold Improvement-Remodeling	1980	1,047		10			1,047	5
6	Leasehold Improvement-Remodeling	1986	559		5			559	6
7	Leasehold Improvement-Remodeling	1990	350		5			350	7
8	Leasehold Improvement-Remodeling	1991	82		5			82	8
9	Leasehold Improvement-Remodeling	1993	7,732		10			7,732	9
10	Leasehold Improvement-Remodeling	1993	6,056		9.7			6,056	10
11	Leasehold Improvement-sign	1994	226	14	12	14		120	11
12	Leasehold Improvement-dryvit	1995	384	24	10	24		203	12
13	Leasehold Improvement-new ac	1999	626	39	15	39		203	13
14	Leasehold Improvement-roof	1985	843	44	19	44		843	14
15	Leasehold Improvement-roof	1994	748	47	15	47		529	15
16	Leasehold Improvement-roof	1997	710	44	15	44		349	16
17	Leasehold Improvement-roof	1998	1,205	75	15	75		507	17
18	Leasehold Improvement-parking lot asphalt	2000	96	32	10	32		63	18
19	Leasehold Improvement-hallway lighting	2001	135	27	10	27		56	19
20	Leasehold Improvement-DAI	2001	169	17	10	17		53	20
21	Leasehold Improvement-bathrooms	2002	630	63	10	63		80	21
22	Leasehold Improvement-Remodeling	2002	91	18	5	18		36	22
23	Leasehold Improvements-Remodeling	2003	1,638	164	10	164		164	23
24	Leasehold Improvements-Remodeling	2003	105	4	4	4		4	24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	6,132		7			6,132	27
28	Leasehold Improvement-Remodeling	2002	5,020	627	7	627		4,392	28
29	Leasehold Improvement-Remodeling	2003	5,251	660	7	660		4,611	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	15,137	378	40	378		1,896	33
34	TOTAL (lines 1 thru 33)		\$ 7,647,724	\$ 275,262		\$ 207,768	\$ (67,494)	\$ 804,037	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 713,229	\$ 91,797	\$ 68,359	\$ (23,438)	various	\$ 306,349	71
72	Current Year Purchases	24,698	2,794	2,794		various	2,794	72
73	Fully Depreciated Assets	40,851	1,098	1,098		various	40,851	73
74								74
75	TOTALS	\$ 778,778	\$ 95,689	\$ 72,251	\$ (23,438)		\$ 349,994	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine/bus/van	:dodge/other	98-'03	\$ 11,860	\$ 2,052	\$ 2,052	\$	5	\$ 11,658	76
77	bus	'01	01	49,826	9,965	9,965		5	29,895	77
78										78
79										79
80	TOTALS			\$ 61,686	\$ 12,017	\$ 12,017	\$		\$ 41,553	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,504,233	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 382,968	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 292,036	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (90,932)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,195,584	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	n/a	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$ n/a	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related party - cost is backed out

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 10,555 Description: copy machine lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Various</u>		\$ <u>687.00</u>	\$ <u>2,748</u>	17
18					18
19	<u>Related party - AMS</u>		<u>883.33</u>	<u>10,600</u>	19
20					20
21	TOTAL		\$ <u>1,570.33</u>	\$ <u>13,348</u>	21

10. Effective dates of current rental agreement:

Beginning 7/1/2001
Ending 7/1/2008

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ 1788k
13. /2005 \$ 1812k
14. /2006 \$ 1836k

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. <u>Skilled nurses on site</u>	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 434,525	\$		\$ 434,525	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			88,042			88,042	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			750,357			750,357	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see page 16A	# of prescrpts				258,878		258,878	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	see page 16A					286,382		286,382	13
14	TOTAL			\$		\$ 1,272,924	\$ 545,260		\$ 1,818,184	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Alden - Des Plaines I

Page 16
Col 5: PT,OT, & ST
Col 6: Other
Amount

XIV. SPECIAL SERVICES (Direct Cost)

Service

1. OT	39-3	\$434,525.00
2. ST	39-3	88,042.00
3.		
4. PT	39-3	750,357.00
5.		
6.		
7.		
8.		
9. Pharmacy	See pg 16A	356,252.70
Plus: Related Party- Forum Drugs		(54,695.00)
Plus: Related Party- Forum I.V.		(42,680.00)
Total to line 9 Pharmacy		258,877.70
10.		
11.		
12. Exceptional Care-Column 3	See pg 16A	0.00
12. Exceptional Care-Column 6	See pg 16A	0.00
13. Other	See pg 16A	565,484.02
Related Party- Pyramid		(76,261.00)
Related Party- CPT		(202,840.77)
Total to line 13		286,382.25
14. Total		1,818,183.95

STATE OF ILLINOIS

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Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 172,915	\$ 212,035	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 63,000)	1,089,027	1,089,027	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		191,521	5
6	Prepaid Insurance	3,970	41,510	6
7	Other Prepaid Expenses	4,066	4,066	7
8	Accounts Receivable (owners or related parties)	229,539	548,073	8
9	Other(specify): Due from Medicare	56,107	56,107	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,555,624	\$ 2,142,339	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,003,985	13
14	Buildings, at Historical Cost		9,685,956	14
15	Leasehold Improvements, at Historical Cost	577,092	1,617,009	15
16	Equipment, at Historical Cost	245,136	245,136	16
17	Accumulated Depreciation (book methods)	(168,912)	(1,207,687)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 653,316	\$ 11,344,399	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,208,940	\$ 13,486,738	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,130,456	\$ 1,130,456	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	89,197	89,197	28
29	Short-Term Notes Payable	1,284,000	1,284,000	29
30	Accrued Salaries Payable	240,346	240,346	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,491	13,491	31
32	Accrued Real Estate Taxes(Sch.IX-B)		272,247	32
33	Accrued Interest Payable	427,266	488,960	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr ins/exp, sales tax	41,231	41,231	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,225,987	\$ 3,559,928	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,120,000	1,120,000	39
40	Mortgage Payable		10,282,341	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,120,000	\$ 11,402,341	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,345,987	\$ 14,962,269	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,137,047)	\$ (1,475,531)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,208,940	\$ 13,486,738	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,151,850)	1
2	Restatements (describe):		2
3	External audit adj made after 2002 cost report was		3
4	submitted. These have no effect on prior yr's report:		4
5	public aid revenues, facility rent	(127,497)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,279,347)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	142,300	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 142,300	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,137,047)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,979,077	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,979,077	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	149,114	6
7	Oxygen	2,023	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 151,137	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	539	12
13	Barber and Beauty Care	1,357	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	11,813	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	540	19
20	Radiology and X-Ray		20
21	Other Medical Services	20,112	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 34,361	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	626	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 626	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	35	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 35	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,165,236	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,256,893	31
32	Health Care	2,275,693	32
33	General Administration	1,916,075	33
B. Capital Expense			
34	Ownership	1,549,655	34
C. Ancillary Expense			
35	Special Cost Centers	2,194,661	35
36	Provider Participation Fee	60,225	36
D. Other Expenses (specify):			
37	<u>Related party salary allocations located</u>		37
38	<u>in column 1 (on pages 3 & 4)</u>	(230,266)	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,022,936	40
41	Income before Income Taxes (line 30 minus line 40)**	142,300	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 142,300	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,488	1,504	\$ 46,896	\$ 31.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	26,275	27,085	797,318	29.44	3
4	Licensed Practical Nurses	8,846	9,186	208,230	22.67	4
5	Nurse Aides & Orderlies	58,662	61,782	758,399	12.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,360	3,428	50,643	14.77	8
9	Activity Director	1,770	2,065	35,386	17.14	9
10	Activity Assistants	4,234	4,513	44,479	9.86	10
11	Social Service Workers	2,015	2,079	38,836	18.68	11
12	Dietician					12
13	Food Service Supervisor	1,995	2,106	44,287	21.03	13
14	Head Cook	6,671	6,962	90,547	13.01	14
15	Cook Helpers/Assistants	40,212	41,773	362,255	8.67	15
16	Dishwashers					16
17	Maintenance Workers	1,822	1,891	35,286	18.66	17
18	Housekeepers	9,542	10,075	88,502	8.78	18
19	Laundry	4,274	4,570	40,435	8.85	19
20	Administrator	2,851	2,959	102,074	34.50	20
21	Assistant Administrator					21
22	Other Administrative	5,871	6,190	153,884	24.86	22
23	Office Manager					23
24	Clerical	6,163	6,308	68,072	10.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,438	1,478	37,697	25.51	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	418	506	9,704	19.18	31
32	Other Health C: Pro Care Mgr	504	523	15,158	28.98	32
33	Other(specify) Clinical SS	551	551	15,794	28.66	33
34	TOTAL (lines 1 - 33)	188,962	197,534	\$ 3,043,882 *	\$ 15.41	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	\$ 3,180	1-3	35
36	Medical Director	monthly	48,200	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,640	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,620	11-3	44
45	Social Service Consultant	18	1,031	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	65	\$ 57,671		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description	Amount	Description	Amount	Description	Amount				
Rosette, Marie	Administrator		\$ 59,204	Workers' Compensation Insurance	\$ 81,798	IDPH License Fee	\$	Advertising: Employee Recruitment	1,219				
Barman, Julie	Administrator		42,870	Unemployment Compensation Insurance	16,634	Health Care Worker Background Check (Indicate # of checks performed <u>44</u>)		IL Health Care Assoc	3,804				
Various exec/ass't admin	executive/admin		36,153	FICA Taxes	231,361	Related party - AMS		Related party - AMS	260				
				Employee Health Insurance	8,126	Surety bond fees		Software license	123				
				Employee Meals	22,358								
				Illinois Municipal Retirement Fund (IMRF)*									
				Related Party-AMS	27,311								
				Related Party-FECII	5,155								
				Union,health,welfare	40,239								
				Dental,pension,life	21,115								
				Empl relations/misc p/r	940								
				Drug tests/401k match/empl vaccine	5,425								
				Mktg empl benefit deduction	(10,590)								
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 138,227	TOTAL (agree to Schedule V, line 22, col.8)	\$ 449,872			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,329				
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
Description			Amount	Description	Line #	Amount	Description	Amount					
			\$			\$	Out-of-State Travel	\$					
							In-State Travel						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Related party - AMS	5,751					
C. Professional Services							Gas, repairs, ins., license	1,483					
Vendor/Payee	Type		Amount										
Alden Management Services	Management fees		\$ 674,804				Seminar Expense						
BDO Seidman	Accounting fees		1,600				Seminars-Medicaid, MDS	610					
Ken Fisch	Legal (collection)		5,611										
Barry Greenburg	Legal		175										
Schmidt,Salzman,Moran	Legal-r/e tax refund		3,390				Entertainment Expense	(
Urban Real Estate Research	Appraisal-r/e tax refund		3,500				(agree to Sch. V, line 24, col. 8)						
Medcom	Billing consultants		215				TOTAL	\$ 7,844					
Misc vendors	Miscellaneous		1,527										
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 690,822	TOTAL		\$							

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	HVAC compressor	1/2002	\$ 3,063	3	\$	\$	\$ 1,021	\$ 1,021	\$ 1,021	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 3,063		\$	\$	\$ 1,021	\$ 1,021	\$ 1,021	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. IL Health Care Assoc., \$5,445
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,177 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 60,225
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 22,358 Has any meal income been offset against related costs? no Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? n/a
d. Have vehicle usage logs been maintained? n/a
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? n/a If no, please explain. n/a
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

Alden Nursing Center - Des Plaines
Reporting Period Beginning
Reporting Period Ending

#42010
1/01/03
12/31/03

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Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(22,358)	Employee Meal
	22	22,358	Employee Meal
22		(6,377)	Uniforms
	10	4,518	Uniforms
	6	137	Uniforms
	4	72	Uniforms
	1	867	Uniforms
	3	444	Uniforms
	11	97	Uniforms
	21	242	Uniforms
19		(6,890)	R/E Tax Appeal
	33	6,890	R/E Tax Appeal
		<hr/> 0	Net should be 0